UNIVERSITY OF TORONTO
FACULTY OF LAW

Clinical Legal Education
Health Equity and Law Clinic
LAW335H1S

Winter 2011

Joanna Erdman
Faculty of Law, University of Toronto

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Health equity is identified by the absence of socially unjust health disparities across population groups, commonly defined by socioeconomic status, race and ethnicity, sex and gender, sexual orientation, age and disability. Health care equity is defined as the absence of systematic and remediable disparities in the delivery of and access to health care across these same groups. Equity thus requires that the distribution of health care resources and the design of health systems, policies and practices promote equality in health outcomes across population groups.

The Health Equity and Law Clinic provides students with an opportunity to explore the role of the law in ensuring equitable health policies and practices in domestic, regional and international contexts. In 2011, the Clinic will focus on policies and practices related to reproductive and sexual health.

The Clinic is based on a clinical seminar model.

The Clinic Component

The Clinic does not represent clients. Students provide legal research, analysis and advocacy support on diverse projects relating to health equity in collaboration with Partner Organizations (government, international agencies, domestic and international NGOs, and other civil society actors).

Projects may include:

- Research memoranda
- Legislative and/or policy reviews
- Assessment of reform initiatives
- Assistance with litigation strategies and case theories
- Drafting of *amicus curiae* briefs, shadow or other consultation reports

The Seminar Component

Students attend a weekly seminar that critically examines the relationship between legal principles of social justice and the conceptual foundations of health and health care equity. The readings are drawn from different disciplines, including epidemiology, medical anthropology, economics, philosophy, and political science. The seminar explores the strengths and weaknesses of legal approaches to health equity, and considers ways in which legal strategies complement other advocacy efforts. Students are also expected to discuss progress on their Clinic Projects and to share challenges in their legal research and analysis (Seminar Grand Rounds).

COURSE EVALUATION

- **Clinic Project (25-30 pp.): 75%**

In the Fall Semester, in consultation with Partner Organizations, the Clinic Director develops the objectives and scope of the Clinic Projects.

At the start of the Winter Semester, each student is assigned a Clinic Project and receives a Background Memorandum that:

  - identifies the Partner Organization (and Partner Organization Contact)
  - describes the objectives and scope of the Clinic Project (e.g. relevant legal issues or facts, geographic focus, project design) and
  - details the procedural requirements, including consultations and works-in-progress (see below)

- **Procedural Requirements: 15%**

These requirements are intended to foster a positive working relationship among students, Partner Organizations, and the Clinic Director and to facilitate the delivery of high quality work products in a timely manner.

  - Code of Conduct: professionalism, competence, conscientiousness, diligence and quality, and information and confidentiality.

  - Consultations: Students are required to discuss ongoing progress with both the Clinic Director and their Partner Organization at least **once** per month.

  - Works-in-Progress: Students are required to submit at least **2** works-in-progress to the Clinic Director and their Partner Organization for review and feedback.

  - Seminar Grand Rounds: Students are expected to discuss progress on their Clinic Projects and to share challenges in their legal research and analysis in the seminar.

- **Class Participation: 10%**

Students are expected to participate in class discussion on assigned readings. Students are also expected to provide colleagues with feedback and assistance in Seminar Grand Rounds.

CLINIC DIRECTOR CONTACT INFORMATION

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SEMINAR OVERVIEW
Monday 2:10-4:00pm, Flavelle Dining Room

1. January 3: Introduction and Course Overview

Part I: Health as a Social Concept

2. January 10: Health Social Movements

3. January 17: Sociology of Health

4. January 24: Determinants of Health

5. January 31: Law as a Determinant of Health

Part II: Health (In)Equity

6. February 7: Defining Health (In)Equity (The Normative)

7. February 14: Measuring and Monitoring Health Equity (The Empirical)

*** February 21: Reading Week (No Class)***

Part III: Remedying Health Inequity

8. February 28: The Politics of Health Equity and Priority Setting

9. March 7: Health Equity and Funding Reform

10. March 14: The Human Rights-Based Approach

11. March 21: International Morality in Debate

March 28 and April 4: Clinic Projects Review

April 28: Deadline for Final Clinic Projects (10:00am)
Submission to Records Office (Received by Clinic Director, NOT Partner Organization)

THE CLINIC SEMINAR

Class 1 (January 3): Introduction & Course Overview

HEAL Clinic Code of Conduct **1**

M. Marmot. "Achieving health equity: from root causes to fair outcomes." (2007) 370 *Lancet* 1153-63. **3**

The WHO Commission on the Social Determinants of Health

Established in 2005, the WHO Commission on Social Determinants of Health seeks to create a global movement for health equity, rooted in shared beliefs in social justice and human rights. The Commission's task to collect, collate and synthesize evidence on the social determinants of health and their impact on health inequity, and to make recommendations for action to address that inequity. This evidence includes what effective social action must entail in order to maintain, promote, and provide better health for all. The Commission released its final report in 2008.

CSDH (2008). *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health.* Geneva, World Health Organization
http://www.who.int/social_determinants/thecommission/finalreport/en/index.html

CSDH (2007). *Civil Society Final Report*
http://www.who.int/social_determinants/themes/civilsociety/en/index.html

PART I: HEALTH AS A SOCIAL CONCEPT

Class 2 (January 10): Health Social Movements

P. Brown and S. Zavestoski. "Social movements in health: an introduction." (2004) 26(6) *Sociology of Health & Illness* 679–694. **14**

G. Scambler and D. Kelleher. "New social and health movements: Issues of representation and change." (2006) 16(3) *Critical Public Health* 219-231. **22**

Class 3 (January 17): Sociology of Health

S. Epstein. "The Construction of Lay Expertise: AIDS Activism and the Forging of Credibility in the Reform of Clinics Trials." (1995) 20(4) *Science, Technology & Human Values* 408-437. **35**

* See next page for description of *Indicators and Benchmarks* and *Social Stratifiers*

Indicators and Benchmarks

Indicators can provide quantitative and qualitative information. They can be used to describe a present circumstance and to measure change over time. There is no commonly agreed or consistent way of categorizing and labeling indicators. Special attention in the health equity context should be paid to: *structural, process* and *outcome indicators.*

- Structural Indicators: measure of key institutions, structures and mechanisms:
  - ratification of international treaties
  - adoption of national laws and policies
  - institutional mechanisms (e.g. regulatory agencies and appeal processes)

- Process Indicators: measure of programs, activities and interventions:
  - proportion of births attended by skilled health personnel
  - number of facilities per population providing basic obstetric care
  - percentage of pregnant women counseled and tested for HIV

  Disparities in health service utilization are complex. They implicate not only availability and accessibility of services but also decision-making dynamics of health system users.

- Outcome Indicators: measure health status or knowledge:
  - Health status: maternal mortality, fertility rates, HIV prevalence rates
  - Knowledge: percentage of women who know about contraceptive methods

Benchmarks are targets to be reached by a set date. Benchmarks allow progress to be measured and are designed to assess the effectiveness of programs, activities and interventions. In their article, Graham and Hussein address problematic aspects of maternal mortality benchmarks.

Social Stratifiers and Health Equity

From a health equity perspective, indicators and benchmarks that reflect the average condition of a population can be misleading. Improvements in average health indicators may mask a decline for some population groups. The *World Health Report 2000* was the source of much controversy in this regard. Critics argued that the measurement of health differences among individuals rather than social inequalities removed health equity and human rights considerations.

Social stratifiers include: wealth, ethnicity, education level, urban versus rural residence, existing health status and age. Reliance on any single stratifier across health indicators may lead to limited and misguided policy recommendations. Health disparities moreover often result from multiple and overlapping forms of social disadvantage. Analysis should therefore consider interactions between stratifiers. It cannot, however, be assumed that groups disadvantaged in one indicator are necessarily the same groups disadvantaged in another.

PART III: REMEDYING HEALTH INEQUITY

Class 8 (February 28): The Politics of Health Equity and Priority Setting

Class 9 (March 7) Health Equity and Financing Reform

Class 10 (March 14): The Human Rights-Based Approach

Class 11 (March 21): International Morality in Debate